Committee on Ways and Means

Medicare Provisions in the *Deficit Reduction Act*

Subtitle A – Provisions Relating to Part A

(1) Improves Hospital Quality

- Expands the requirements for required hospital quality reporting.
- Requires hospitals to report on existing complications and comorbidities upon admission in FY 2007. The Secretary will select (at least two) hospital-acquired infections that have been determined by the Centers for Disease Control and Prevention (CDC), specialty societies and others to be preventable from best evidence-based guidelines in FY 2007. Implements an offset to account for extra payments above the base payment that result from the (selected) hospital-acquired infections in 2008.

(2) Clarifies determination of Medicaid patient days for disproportionate share (DSH) computation

- Codifies policy regarding exclusion of patient populations receiving medical assistance under Section 1115 expansion waiver demonstration programs, and excludes patients not receiving hospital benefits under such authority from the Medicaid days component of the calculation for purposes of Medicare disproportionate share inpatient hospital payments.

(3) Increases Payments to Medicare-Dependent Hospitals

- Extends the special payment adjustment for the hospitals categorized as "Medicare Dependent" from October 1, 2006 to October 1, 2011.
- Increases the amount of payment available to Medicare Dependent hospitals and updates the cost year for purposes of determining the payment.

(4) Reduces payments to skilled nursing facilities for bad debt

- Reduces Medicare program payments for unpaid coinsurance (bad debt) by individuals who are not dually eligible for Medicaid to 70 percent.
- Retains bad debt payment at 100 percent for dual eligible beneficiaries.

(5) Extends phase-in of the inpatient rehabilitation facility classification criteria

- Adds an additional year in the transition period for the 75 percent rule.
- Retains the 60 percent threshold for 2006.
- Threshold increases to 65 percent in 2007 and to 75 percent in 2008.

(6) Develops a strategic plan for physician investment in specialty hospitals

- Suspends issuance of new provider numbers at the earlier of six months or until HHS issues a strategic implementation plan on specialty hospitals to address investment, care

for low income and uncompensated care. Requires consultation with Congress in devising the strategic plan.

(7) Establishes a post-acute care demonstration

- Creates a three-year demonstration program by January 1, 2008 to analyze costs and outcomes across different post-acute care settings following hospitalization.
- Provides participating patients and providers standardized tools to review and improve patient conditions for effective, focused post-acute care.

(8) Establishes a Medicare gainsharing demonstration

- Creates a demonstration program to evaluate gainsharing arrangements between hospitals and other providers at up to six sites, beginning on January 1, 2007.
- Requires a final report to be submitted to Congress on the outcome of the project by May 1, 2010.

Subtitle B – Provisions Relating to Part B

(1) Allows beneficiary ownership of certain durable medical equipment (DME)

- Provides for beneficiary ownership of certain items of DME after the 13th month of rental (for items for which rental begins after January 1, 2006.)
- Provides for beneficiary ownership of oxygen equipment after 36th month of rental.
- Pays for service and maintenance of such DME when such maintenance is actually provided.
- Continues the current law first month purchase option for power wheelchairs.

(2) Reforms payments for imaging services

- Achieves savings from reductions in reimbursements for multiple images on contiguous body parts in 2006 and 2007. These savings would be returned to taxpayers rather than to physicians as increased practice expenses for other services.
- Ensures that payment rates for imaging services delivered in physician offices do not exceed payment rates for identical imaging services delivered in hospital outpatient departments.

(3) Reforms payments for procedures in ambulatory surgical centers (ASCs)

- Ensures that payment rates for services delivered in ASCs do not exceed payment rates for the same services in hospital outpatient departments. Begins January 1, 2007.

(4) Updates payments for physician services

- Prevents physician payment cuts in 2006 by providing a freeze in payment rates for physician services.

(5) Provides three-year transition of hold harmless payments for small rural hospitals

- Provides a phased transition from the pre-August 2000 payment policy to the hospital outpatient payment system for small rural hospitals.

(6) Increases payment for dialysis services

- Provides a 1.6 percent update to end-stage renal disease (ESRD) facilities for 2006.

(7) Revises payment for therapy services

- Allows therapy caps to take effect in 2006, per current law. Allows patients to apply for additional therapy services if their treatment is expected to exceed the cap.
- Requires the Centers for Medicare and Medicaid Services (CMS) to improve coding to reduce inappropriate payments for therapy services.

(8) Accelerates implementation of income-relating the Part B premium

- Changes the phase-in of income relating the Part B premium, (which begins in 2007 as enacted in the *Medicare Modernization Act*) from five years to three years for the highest income seniors.

(9) Improves preventive benefits.

- Provides preventive screening for abdominal aortic aneurysms for beneficiaries at risk during a Welcome to Medicare physical exam. Waives the deductible for the screening.
- Waives the deductible for colorectal cancer screening tests that are covered by Medicare.

(10) Improves delivery of services at federally-qualified health centers (FQHCs)

- Adds diabetes self-management training and nutrition therapy benefits, as covered under Medicare, to additional services that may be covered under the all-inclusive per-visit payment rate for these centers.
- Allows FQHCs to consolidate billing of Medicare for services provided through contractors.
- Removes restrictions on receipt of homeless grants.

(11) Waives Part B late enrollment penalty for certain international volunteers

- Waives Part B late enrollment penalty for volunteers who are overseas for 12 months serving with a 501(c)(3) organization. Requires such volunteers to prove that they purchased alternative health insurance while overseas to qualify for the waiver.

Subtitle C – Provisions Relating to Parts A and B

(1) Revises home health payments

- Provides a one year freeze in the home health payment rate for 2006.
- Includes a 5 percent rural add-on for rural home health agencies for 2006.
- Institutes quality reporting for home health in 2007. Agencies that report will receive the market basket update. Those that do not report will receive market basket minus 2 percentage points.

(2) Revises period for providing payment for claims that are not submitted electronically

- Extends the period for payment of non-electronic claims from 26 days to 28 days to encourage electronic submission.

Subtitle D – Provisions Relating to Part C

(1) Provides for phase-out of budget neutrality for risk adjustment for Medicare Advantage (MA) plans

- Codifies the Administration's phase out of the budget neutrality adjustment during 2006 – 2010.
- Requires the Secretary to conduct a study to determine if there are differences in coding patterns between MA and fee for service. To the extent that there are differences, the Secretary shall make adjustments to risk scores and the budget neutrality factor. If no differences are identified, no adjustment will be made. Only allows for an adjustment, if any, during 2008, 2009, and 2010.
- Makes no permanent changes to Medicare Advantage payment calculations.

(2) Provides grant program for rural Programs for All-Inclusive Care for the Elderly (PACE) sites

- Provides grants to help start up rural PACE sites and provides limited payments for outlier cases in the first three years of a site's operation. PACE sites provide services to older individuals who are nursing home eligible in a manner that enables them to remain in the community as long as possible.

Total: Net Medicare Savings of approximately $6 billion, FY 2006 – 2010.